EXHIBIT 6

Email to Former GPD Chief, Hassan Aden These emails support the Plaintiff's claims regarding:

- The Twitter tweet to former GPD Chief, Hassan Aden
 - GPD's refusal of jurisdiction
- ECU Health's refusal to allow Plaintiff to speak to their police
- Communications between Vicki Haddock and SBI agents
 - The SBI mystery investigation prior to September 13, 2014
- The GPD/SBI Official Investigation November 2014

Subject: hassan aden (@chiefaden) replied to one of your Tweets!

Date: September 9, 2014 at 9:32 PM EDT

From: hassan aden (via Twitter)<notify@twitter.com>

To: avens1@charter.net





c denise,

hassan aden replied to your Tweet!





c denise

@C__Denise

@chiefaden conduct was culpably negligent and proximately caused Keisha W's death @Vidant_Health. No one wil investigate. #Manslaughter - 10 Sep

hassan aden

@chiefaden



@C__Denise @Vidant_Health Please elaborate via email. Thank you. Haden@greenvillenc.gov.

01:32 AM - 10 Sep 14

Reply to @chiefaden





Forgot your Twitter password? Get instructions on how to reset it.

You can also unsubscribe from these emails or change your notification settings. Need help? If you received this message in error and did not sign up for Twitter, click not my account. Twitter, Inc. 1355 Market St., Suite 900 San Francisco, CA 94103

Subject: Elaboaration to Twitter Resonse Date: September 9, 2014 at 10:08 PM EDT From: avens1@charter.net>

To: Haden@greenvillene.gov

My daughter, Keisha White, was on oxygen, was connected to an oxygen monitor, and an electronic monitor. She was placed in wrist restraints at about midnight on the morning of 5/10/2014 to keep her in the bed. Both of her monitors ceased to give readings at approximately 3:00 a.m. Initially, I was told that the nurse didn't reconnect the monitors since Keisha had been pulling the leads (monitor wires that are attached to sticky patches and stick to the chest) off. But if she was in restraints for 3 hours, this should not have been a factor. Then I was told that the nurse noted my daughter to be resting peacefully at 3:30 a.m. and did not want to disturb her. But 3:30 a.m. is the time that I asked the nurse to give Keisha her pain medications. And if she administered medicines at 3:30, ensuring Keisha was properly connected to her monitors should not have caused any more of a disturbance.

When she went back to Keisha's room at 5:45a.m. to give the next dose of medicine, Keisha was found lifeless, in wrist restraints, unable to have pressed the call button, (more than likely her door was closed because it usually was when I went there, therefore cries for help while fighting for air would not have been heard) and code blue was called.

I had left the hospital for a little while and returned just in time to hear the code blue for my daughter's room on the intercom as I approached the elevator. It took the rescue team so long (10 – 15 minutes) to get a heartbeat, that by the time they got one, she was already brain dead. I decided to take her off life support at 1:00 p.m. Time of death was 1:02. She was so brain dead that she only lived 2 minutes once the machine was turned off. Since I had left her room, I had no idea she was not connected to the monitors. I thought the monitors signaled the need for the code blue.

I believe the care provided by the responsible medical professionals exceeded the meaning of gross negligence, because (1) the responsible parties knew Keisha was not connected to her monitors, (2) they knew she was in wrist restraints and totally dependent on them for her care, (3) they made a conscious decision to not ensure she was connected to the equipment at all between approximately 3:00a.m. and 5:45a.m, and (4) they made a conscious decision to not increase human assessment during the time she was in restraints and not connected to her monitors while knowing she was experiencing symptoms of apnea earlier in the morning and night.

There was a serious breach of duty by those who were obligated to provide necessary and life sustaining treatment between the hours of 7:00 p.m. on the night of May 9, 2014 and 5:45 a.m. on May 10, 2014. This breach of duty caused Keisha White to suffer unnecessarily, violated her civil rights to freedom, as well as, to proper medical care, eliminated her ability to access the nurse call button should she need anything, deprived her of essential monitoring that could have saved her life, caused her a greater sense of fear and anguish and confusion other than what's normally felt after being hospitalized, compromised her ability to communicate with the staff because she was abandoned during her most critical hours of need, and ultimately, became the cause of her death. She, Keisha White, my daughter, Vidant Medical Center's patient, deserved better than this.

Keisha White, and her family entrusted the staff to treat her with the dignity and respect she was entitled to, and trusted the staff to perform all treatment options to the best of their ability. An accident is the occurrence of an unforeseen event. Medical professionals are trained to foresee possible consequences of the medical actions they perform, as well as the possible consequences of necessary medical actions they neglect to perform. The information I have been disclosed shows that the staff who were responsible for Keisha's care made intentional choices that were voluntary and aware of in thought. Yet, they made those choices without any regards to her safety and well-being. The results of those choices may not have been intentional, but those choices were not accidental.

I know this case has a criminal element to it and believe it's involuntary manslaughter, but I can't get anyone to listen to me. District Attorney Futrell of the Pitt County courthouse refused point blank. He says his boss

supported his decision. I went to the Greenville Police Department and they said I needed to talk with Vidant's Police Department. Vidant's Police Department won't talk to me unless Vicki Haddock gives the okay, which is a HUGE conflict of interest, because she works in RIsk Management and her job is to protect the hospital. I need an external investigation; an external criminal investigation.

I know I have a civil suit and the hospital has already offered me a 6-figure settlement. What i don't understand is if this case does NOT have a criminal elementt to it (such as manslaughter), why Vicki Haddock has had several communications with SBI. She has talked with several agents including Agnent Burnell and Agent Smith. They both told me that they are not brought in on cases this way. Initially, I was told that neither had spoke with Vicki HAddock and knew nothing of my daughter. Then I found out from Ms Haddock that in a conversation she had with them, not only did they tell her I had spoke to them, but that I had also spoke to the DA. I did not tell Ms HAddock that I spoke with the DA. Finally, after confronting the SBI again, they acknowledged the conversations but was able to do very little to help me. Again I ask, why is this communication ongooing if there's no criminal element. So, I intend to do everything possible to bring about an external investigation. If an investigation shows that the hospital staff may be guilty of manslaughter or criminal negligence, then I want charges brought. If anyone tried to cover it up, I want obstruction of justice charges brought. If anyone knows what happened with my daughter the morning of May 10, and did nothing, I want accessory charges brought. I want justice. My daughter's rights were violated when the staff violated federal restraint protocol. IS there anything you can do to help me?

My contact information is

400 Poplar ST Weldon, NC 27890 252-678-8300

THANK YOU so much for your time and for responding to my tweet!!

* Some of the information in this en email was based on misunderstanding and misinformation. on Misunderstanding and misinformation.

For Example, Brixon did not go to White's room at the Example, Brixon did not go to White's room at the Example, brixon did not go to White's room at the Example. The Plaintiff misunderstood Agent Varnell's name.

* The Plaintiff misunderstood Agent Varnell's name. Initially, she thought his name was Burnell.

Subject: Re: Elaboaration to Twitter Resonse (PART 2)

Date: September 13, 2014 at 8:09 PM EDT From: avens1@charter.netavens1@charter.net

To: HAden@greenvillenc.gov

On Sat, Sep 13, 2014 at 6:57 PM, Hassan Aden wrote:

Ms. White,

I have reviewed the information in your e-mail and I assigned someone from our Major Crimes Unit to look into this matter. We have been made aware that both the SBI and the Pitt County District Attorney's Office have looked into this matter previously. Our Detective spoke with the SBI agents and with Asst. District Attorney Anthony Futrell about this matter. It is our conclusion that if you have evidence to present that would support a criminal investigation, into this matter, please contact the SBI as they handled the original investigation. The Pitt County District Attorney's Office may be a resource for you. Thank you.

Hassan Aden

Chief of Police Greenville Police Department 500 South Greene Street Greenville, NC 27834

On Sep 9, 2014, at 10:10 PM, "avens1@charter.net" < avers1@charter.net wrote:

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THANK YOU so much for your time and for responding to my tweet!!

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If you as intended recipient have received this e-mail incorrectly, please notify the sender (via e-mail) immediately.

Subject: Re: New Info regarding death at Vidant Medical Center

Date: November 7, 2014 at 12:28 PM EST From: avens1@charter.net>

To: HAden@greenvillenc.gov

When will we talk? How will you get this information?

On Fri, Nov 7, 2014 at 8:03 AM, Hassan Aden wrote:

Ms. Avens-I will facilitate a review of the new information. It will likely include GPD, SBI and the Pitt County DAs office.

Again-I am sorry for your loss. Thank you.

Hassan Aden

Chief of Police Greenville Police Department 500 South Greene Street Greenville, NC 27834

On Nov 7, 2014, at 4:05 AM, "avens1@charter.net" < avens1@charter.net> wrote:

Cynthia Avens 400 Poplar St Weldon, NC 27890 252-678-8300

Hi Chief Aden,

I spoke with someone at the US Attorny General's THursday evening about 5pm. He suggested I talk to you again about launching an investigation into my daughter's death at Vidant Medical Center. He told me that because the hospital has it's own PD should not be an issue, and that the matter should investigated by you, then passed to the DA for determination on whether to prosecute.

I have new information. Since the last time we've communicated, I've received 1600 pages of medical records to substantiate my claims of murder by Linda Brixon and Monica Baker Wilson as well as possible accessories to the crime. I also have a 36 page report regarding the findings from an investigation by the NC DHHS that explicitly states that the hospital violated 6 standards of care. The report also explicitly points out where the staff members failed my daughter's care. And it provides witness testimony/statements pointing out Brixon DELIBERATELY refused care to my daughter even though my daughter was in "immediate jeopardy" and had been in "cardiac arrest" all night. There's several accounts where Brixon was informed of my daughter's oxygen level being as low as 62%, and she still REFUSED to provide life-sustaining care and NEGLECTED to inform the physician of changes in my daughter's behavior, stats, and condition. She lied in the records to cover up her crime which is felony obstruction of justice for falsifying records to elude suspicions. Because of the EGREGIOUS nature, and the fact that my daughter was INTENTIONALLY left in restraints even after reaching the point they were supposed to be removed (according to DHHS)... another area of the records that I believe were falsified but yet contradicted statements and standards.... she should be charged with first degree murder for the torture my daughter endured. If you find that it does not qualify as torture, omission of a legal obligation resulting in death is second degree murder. That's where the charge

nurse, Monica Baker Wilson comes in at. Even though her statements in the report attempts to shield herself and her role in my daughter's death, she does contradict herself. In addition to that, I was there. I know for a fact that she knew what was going on with my daughter when she made the choice to do nothing (OMISSION) while yet holding the title "CHARGE NURSE."

I do look forward to discussing this with you further and submitting the evidence I have to you.

Sincerey,

Cynthia Avens

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